NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Spotlight on Progress

Crisis Services
Promoted Statewide

A Quarterly Update on the Strategic Plan

DIVISION OF MENTAL HEALTH , DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

dhhs
nc department of health and human services

MH | DD | SAS
division of mental health | developmental disabilities | substance abuse services

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Integrating Crisis Services in Community Systems of Care

We are now half way through the three years of the Division's ***State Strategic Plan 2007-2010***. Considerable progress has been made with all strategic objectives through detailed planning and many conversations and collaboration with multiple organizations.

We offer this State Strategic Plan update on ***crisis services*** to give you an idea of changes occurring at the state and local levels. Progress in expanding crisis services in our state is well under way and is due to the contributions of:

- The North Carolina General Assembly
- The Secretary of the Department of Health and Human Services (DHHS)
- DMH/DD/SAS (the Division)
- Division of Medical Assistance (DMA)
- Division of Health Service Regulation
- Local Management Entities (LMEs)
- Providers
- Consumers, family members, and advocacy organizations
- Professional organizations
- NC Hospital Association

One of the five objectives of the Division's State Strategic Plan 2007-2010 focuses on ***comprehensive crisis services.***

Action steps include:

- Involvement of consumers in crisis services planning.
- Comprehensive services and continuity of care.
- Positive outcomes for consumers.
- Crisis intervention and stabilization training techniques.
- Protocols among local crisis services and community hospitals, primary care physicians, clinics, and other community agencies.
- Appropriate use of the state's psychiatric hospitals and alcohol and drug abuse treatment centers.

Accessing Crisis Services

Any person can receive crisis and emergency services in North Carolina.

Regardless of where you are in the state, simply call the LME's crisis telephone hotline at any time. The trained person answering the crisis line arranges for the right service for you and your situation. You can receive crisis services regardless of your ability to pay.

As a keystone in North Carolina's public MH/DD/SA service system, person-centered planning for each consumer includes: planning to know and recognize clues of a potential crisis, taking action steps to prevent a crisis reoccurrence, and providing the right intervention when a crisis occurs.

Initial Groundwork & Support for Expansion

In July 2006, the General Assembly designated $5.2 million for LMEs to develop long-term plans and for operational start-up of local crisis services (Session 2006, Senate Bill1741). Additional funds provided in session 2007 (House Bill 1473) were designated for continued implementation of these plans. Over state fiscal years 2007 and 2008, each LME developed a long-term plan and worked with providers to establish new crisis services.

As of July 2008, LMEs reported the use of the initial crisis services funds: 14 LMEs have facility-based crisis services; 13 have local inpatient services; 11 LMEs have mobile crisis teams; eight have crisis respite beds; seven LMEs have detox services; four have after-hour crisis services; four LMEs have transition beds; three have walk-in crisis services; three have peer support services; two LMEs have emergency department safe areas; and one LME has telemedicine.

In early 2008, Secretary Dempsey Benton established an Advisory Group to recommend strategies for consistent crisis services expansion statewide. The Advisory Group consisted of professionals from universities, medical centers, LMEs, providers, professional organizations, consumer organizations and the Division.

In July 2008, the General Assembly passed House Bill 2436 approving additional funding for the start-up and operations of the crisis services recommended by the Secretary's Advisory Group.

House Bill 2436 funding for statewide crisis services:

- $5,755,000 for mobile crisis teams
- $5,113,947 for walk-in crisis and immediate psychiatric aftercare
- $1,876,243 for START crisis teams
- $1,080,991 for crisis respite beds
- $8,121,644 for local inpatient psychiatric beds/bed days

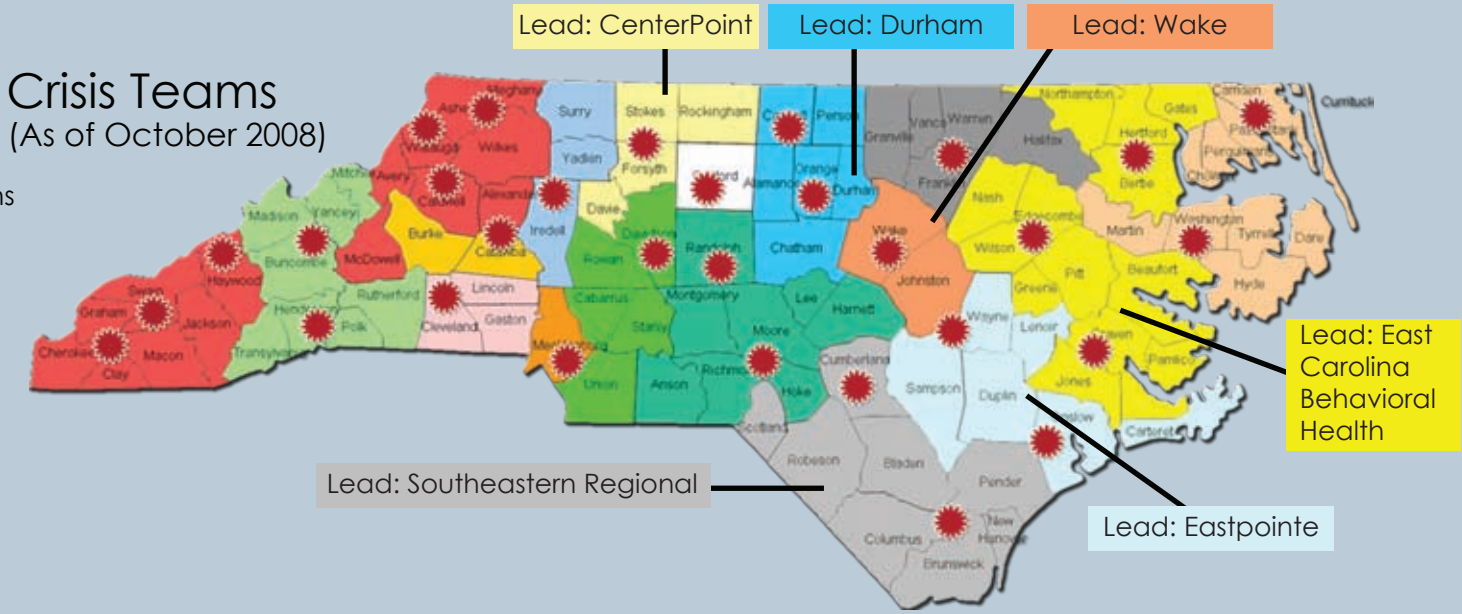
Spotlight: Mobile Crisis Management Teams

The Division has divided the entire state into areas to be covered by 30 mobile crisis teams. Seventeen of the 24 LMEs host the 30 teams. The area covered by a team does not always align with an LME's boundary. In September 2008, the Division distributed funding from the General Assembly to the host LMEs to start and support the 30 teams. As of December 2008, 26 of the 30 teams have hired staff.

North Carolina Mobile Crisis Teams

Receiving House Bill 2436 Funding (As of October 2008)

Denotes mobile crisis team locations



What is a mobile crisis team? In response to a crisis call, the LME may send a mobile crisis team to provide assistance at the location of the crisis. Team members evaluate the situation, provide immediate services for the individual or family, and arrange for ongoing services. Mobile crisis teams are available 24 hours a day, seven days a week, year round. The Division and LMEs collaborated to identify available and willing qualified providers of the mobile crisis teams. Each mobile crisis team is endorsed by their LME and enrolled by DMA as Medicaid providers.

Who staffs a mobile crisis team? A mobile crisis team includes five or more professionals - a nurse, clinical social worker or psychologist, and other professionals and paraprofessionals with experience in mental health, substance abuse, developmental disabilities, and crisis management. A psychiatrist is available at all times.

Spotlight: Walk-in Crisis and Psychiatric Aftercare

In September 2008, the Division distributed funds to LMEs to establish 30 walk-in crisis and psychiatric after care programs. This funding pays for the services of the psychiatrists and other staff and for telepsychiatry equipment. LMEs are currently finalizing locations and staffing for the programs.

What is walk-in crisis and psychiatric aftercare?

At a walk-in site an adult, adolescent, or family in crisis can receive immediate care. The care may include an assessment and diagnosis for mental illness, substance abuse, and developmental disability issues as well as planning and referral for future treatment. Other services may include medication management, outpatient treatment, and short-term follow-up care. Psychiatric aftercare may also assist consumers returning to the community from a state psychiatric hospital or alcohol and drug abuse treatment center until they are established with a local clinical provider.

Who staffs walk-in crisis and psychiatric aftercare?

A psychiatrist, registered nurse, and clinical social worker are available to provide services. Services may be given face-to-face or by telepsychiatry equipment that allows a psychiatrist at a distant location to talk with and see consumers privately through closed-circuit television connections. This arrangement makes scarce psychiatric services available across the state, even in remote locations.

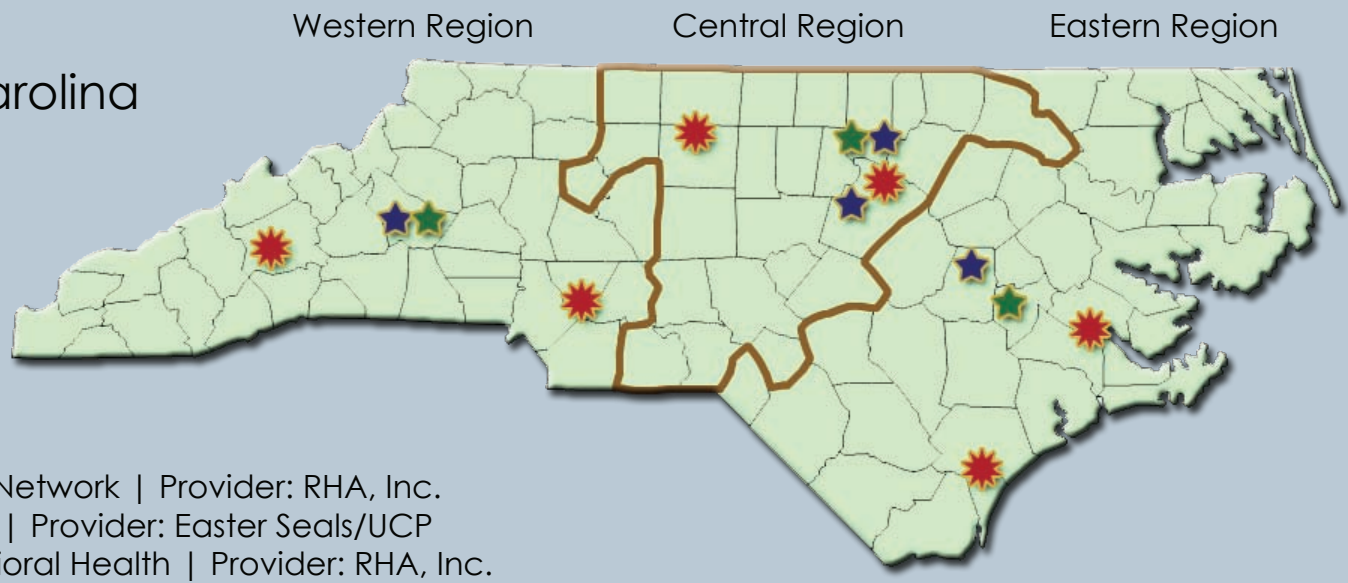
Spotlight: START Teams and Crisis Respite Beds

Each of the three regions of the state now has two START teams. In September 2008, the Division awarded funds to one LME in each region to establish two clinical START teams and one four-bed crisis respite facility.

START Teams Locations and Coverage Areas in North Carolina

(As of October 2008)

- Denotes State Psychiatric Hospital
- Denotes State Developmental Center
- Denotes START Team



Western Region - LME: Western Highlands Network | Provider: RHA, Inc.
Central Region - LME: The Durham Center | Provider: Easter Seals/UCP
Eastern Region - LME: East Carolina Behavioral Health | Provider: RHA, Inc.

Source: NC DMH/DD/SAS State Operated Services

Who staffs a START team? The START teams consist of a team leader and two Master or Bachelor level qualified professional team members. The teams have access to ongoing psychological and psychiatric consultation.

What is START? A ***S***ystemic/***T***herapeutic/***A***ssessment/***R***espite/***T***reatment team, better known as ***START***, is a national model of crisis prevention and intervention supports and services. START works with individuals with intellectual and/or developmental disabilities and behavioral healthcare needs. START helps prevent unnecessary hospitalizations, promotes transitions to the community from state developmental centers, and keeps individuals in their communities.

START teams help families and providers 24 hours a day, seven days a week. At the request of a provider or family, and often working with a mobile crisis team, a START team evaluates a person in crisis. The START team provides immediate crisis care and arranges clinical and emergency meetings to plan ongoing treatment. START teams consult with and train community providers and others such as hospital staff. The teams help develop collaboration across disciplines and coordinate services for high risk individuals.

Spotlight: START Teams and Crisis Respite Beds (continued)

How does crisis respite help? Crisis respite provides direct intervention and clinical services to a person at a location usually away from the person's home. Respite care also provides relief for the family or primary caregiver. A Masters level respite director oversees respite staff and ensures 24-hour awake staff. Two beds are reserved for planned respite (up to 72 hours) and two beds are for crisis respite (up to 30 days). The START team remains actively involved during all respite stays.

We anticipate the six START teams and 12 crisis respite beds will be fully operational by January 2009. The providers of the START teams are developing a public awareness campaign to inform communities about the START teams and crisis respite facilities. START teams and crisis respite facilities.

Spotlight: Community Hospitals and Inpatient Psychiatric Beds

Interested community hospitals, LMEs, and the Division are negotiating contracts for new inpatient psychiatric beds. Funding is available from the General Assembly for about 76 new beds. A progress report is due to the General Assembly by March 1, 2009.

What is the role of community hospitals with community crisis services? Community hospitals with psychiatric inpatient beds play an important role by providing immediate short-term, intensive crisis care for individuals close to home and their family and friends. LMEs help consumers with admission to the hospital and ensure continuity of care when ongoing services are needed after crisis stabilization.

Community hospitals may provide assessment, medication management, psychiatric care, or inpatient medical detoxification. Local inpatient crisis services are short-term. If a person needs long-term and more intensive treatment, the LME facilitates a transfer to a state-operated facility.

What is the agreement between community hospitals and LMEs? The detailed requirements and expectations for community hospital inpatient psychiatric beds are outlined in a three-way contract with the community hospital, the LME, and the Division. The contract covers such items as authorization of service, payment rates, billing procedures, relationships between LMEs and hospitals, and the necessary protocols for expediting the transfer of an individual to a state psychiatric hospital if necessary.

Spotlight: Division's Alcohol and Drug Abuse Treatment Centers

Each of the three state Alcohol and Drug Abuse Treatment Centers (ADATCs) has expanded the number and use of beds for acute crisis services.

The Division restructured the three ADATCs to increase capacity to provide appropriate acute care and treatment. As a result, the ADATCs served 699 more individuals in acute crisis and 632 more individuals in acute rehabilitation through May 2008 when compared to 2007.

Spotlight: Continuity of Care after the Crisis

Continuity of care means the ongoing support and treatment for a person stabilized following a crisis. The LME is responsible for ensuring that care is coordinated throughout the system, particularly for individuals who have no connection with a clinical home provider after a crisis and for individuals who are at high risk of frequent crisis services.

A provider of crisis services ensures continuity of care for consumers. For example, a mobile crisis team or the staff at a walk-in crisis site secures a community referral and appointment for the individual. In preparation for discharge from a community hospital, state psychiatric hospital or ADATC, the staff of the facility, the LME care coordinator and the provider prepare a discharge plan with the person.

The plan identifies the person's clinical home provider, needed services, and the locations and times of next appointments. The discharge plan may involve medication management and an initial consultation with a psychiatrist through walk-in crisis and psychiatric aftercare. The plan spells out the responsibilities of the consumer, family, and providers.

Bed Expansion Status in Alcohol and Drug Abuse Treatment Centers

- Walter B. Jones ADATC in Greenville opened a new 24-bed acute crisis unit in July 2008.
- J.F. Keith ADATC in Black Mountain currently operates a 10-bed acute unit and 70 acute rehabilitation beds. The 30-bed acute unit will be completed by the end of December 2008.
- R.J. Blackley ADTAC in Butner added five acute beds designated for females.

Moving Forward: Crisis Prevention & Intervention Planning

We are excited about the progress of MH/DD/SA crisis services in North Carolina. The increased number of mobile crisis teams, the introduction of START teams and crisis beds, and the expanded programs at the ADATCs are positive steps. We look forward to the establishment of the walk-in centers and additional local inpatient psychiatric beds in community hospitals. The community system of care is becoming more efficient, accessible, responsive, and fully integrated to assist anyone in crisis wherever they live.

Between now and June 2010, the Division's ***State Strategic Plan 2007-2010*** calls for other activities related to the objective on crisis services:

- Continued enhancement of state and local crisis services.
- Needs assessment and service gaps analysis.
- Appropriate use of local law enforcement and courts in crisis situations.
- Improved guidelines for involuntary outpatient and inpatient commitment processes.
- Ensuring successful performance of crisis services.

"Spotlight on Progress" provides updates on topics covered in the State Strategic Plan.
We are always open to your feedback and suggestions at contact_dmh@ncmail.net.

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